Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Rollin Thrift, MD

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-14-1664-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies…"

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on February 18, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2013	Designated Doctor's Examination	$950.00	$950.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.210 defines the medical documentation that is required for medical bills from a health care provider.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16Q – Claim/service lacks information which is needed for adjudication. *Please submit DWC-69.*
   - 16R – Claim/service lacks information which is needed for adjudication. *Please submit medical records.*

- 18 – Duplicate claim/service.

Issues

1. Did the requestor supply the appropriate documentation for adjudication of the billed claim?
2. Is the requestor entitled to reimbursement?
3. What is the appropriate fee for the examination in question?

Findings

1. Per 28 Texas Administrative Code §133.210 (b), "When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents." Submitted documentation includes evidence that a 26-page fax was submitted to Tristar, acting on behalf of the self-insured City of San Antonio, on 11/5/13. Therefore, the Division finds that the appropriate documentation for adjudication of the billed claim.
2. Per 28 Texas Administrative Code §133.210 (d), "Any request by the insurance carrier for additional documentation to process a medical bill shall: (1) be in writing; (2) be specific to the bill or the bill's related episode of care; (3) describe with specificity the clinical and other information to be included in the response; (4) be relevant and necessary for the resolution of the bill; (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider; (6) indicate the specific reason for which the insurance carrier is requesting the information; and (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation." Because the required documentation was submitted with the initial billed claim, if the obligation of the insurance carrier to request any *additional* documentation in accordance with 28 Texas Administrative Code §133.210 (d). The documentation submitted does not support a request for additional documentation filed in this manner. Therefore, the Division finds that the preponderance of evidence supports that the requestor is entitled to reimbursement.
3. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Therefore, reimbursement for the examination to determine Maximum Medical Improvement is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area." The billing presented includes three units to indicate three body areas rated for Impairment Rating. The Request for Designated Doctor (DWC032) indicates the request for impairment included cervical and lumbar spine (musculoskeletal spine and pelvis), right shoulder and elbow (musculoskeletal upper extremity), right hip and left knee (musculoskeletal lower extremity), and left head and face (non-musculoskeletal body structure). The narrative submitted indicates a full physical evaluation with range of motion with findings for impairment rating was performed for the spine, upper extremity, lower extremities, and an impairment rating for the head/face. Therefore, the appropriate fee for the examination for impairment rating is $750.00.

   The appropriate fee for the total examination was $1100.00. The requestor is seeking $950.00. Therefore, the recommended fee is $950.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $950.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $950.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 17, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.